

AMENDED IN ASSEMBLY AUGUST 19, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL

No. 1686

Introduced by Assembly Member Pacheco

February 21, 2003

~~An act relating to health care benefits. An act to add Article 15 (commencing with Section 870) to Chapter 1 of Division 2 of the Business and Professions Code, and to amend Section 1371.35 of the Health and Safety Code, relating to health care.~~

LEGISLATIVE COUNSEL'S DIGEST

AB 1686, as amended, Pacheco. ~~Health care providers: unfair billing practices.~~

Existing law, the Medical Practice Act, regulates the practice of physicians and surgeons by the Medical Board of California.

This bill would encourage local medical societies to establish a process to resolve billing disputes between a contracting physician group and a noncontracting physician or physician group, as defined. The bill would, upon the request of a contracting physician group or noncontracting physician or physician group, authorize a local medical society to convene a panel to hear and attempt to resolve a billing dispute. The bill would require a panel to render an advisory letter to the parties if the panel determines that the parties are unwilling to agree. The bill would provide that the advisory letter would not be binding on the parties, but would be admissible in any court action.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law prescribes a

specified process for payment of health care service plan claims from contracting and noncontracting providers for emergency services and care. A violation of the act is a crime.

This bill would prohibit a health care service plan from paying a claim submitted by a noncontracting provider under certain conditions, including when the claim was submitted by a noncontracting provider to a contracting provider for payment and the amount of the claim is disputed by the contracting provider.

Because a violation of the bill would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under the act, a health care service plan is required to make a dispute resolution mechanism available to a health care provider who does not contract with the plan to resolve billing and claims disputes and to meet specified financial security standards to ensure payment of their claims.~~

~~This bill would declare the findings of the Legislature that certain of these noncontracting providers engage in improper billing practices and its intent to prevent those practices.~~

~~Vote: majority. Appropriation: no. Fiscal committee: no—yes. State-mandated local program: no—yes.~~

The people of the State of California do enact as follows:

1 ~~SECTION 1.—The Legislature finds and declares that certain~~
 2 *SECTION 1. Article 15 (commencing with Section 870) is*
 3 *added to Chapter 1 of Division 2 of the Business and Professions*
 4 *Code, to read:*

5
 6 *Article 15. Local Medical Society Dispute Resolution*

7
 8 *870. It is the intent of the Legislature that local medical*
 9 *societies be encouraged to establish a process that will promote the*

1 resolution of payment disputes over services provided to health
2 care service plan enrollees or persons covered by an insurer that
3 arise between a medical group directly contracting with a health
4 care service plan or insurer and a physician and surgeon or group
5 of physicians and surgeons who do not contract with, are not
6 employed by, or are not otherwise affiliated with the medical group
7 that is party to the dispute. This process would provide a forum
8 whereby physicians in a dispute over reimbursement can
9 voluntarily have their dispute heard and evaluated by a group of
10 peers serving in the same community as the disputing parties.

11 871. (a) "Contracting physician group" means a group of
12 licensed physicians and surgeons that directly contract to provide
13 health care services to enrollees of a health care service plan
14 licensed under Chapter 2.2 (commencing with Section 1340) of
15 Division 2 of the Health and Safety Code, or of an insurer licensed
16 or holding a certificate of authority to transact health insurance
17 under the Insurance Code. This group is financially responsible for
18 all covered medical services pursuant to their contract with the
19 health plan.

20 (b) "Noncontracting physician or physician group" means a
21 licensed physician and surgeon or a group of licensed physicians
22 and surgeons who have provided health care services to an
23 enrollee of a health care service plan licensed under Chapter 2.2
24 (commencing with Section 1340) of Division 2 of the Health and
25 Safety Code. A noncontracting physician or physician group has
26 no contractual obligation or relationship for the payment of the
27 provided services with a contracting physician group.

28 872. (a) Upon request of a contracting physician group or a
29 noncontracting physician or physician group, a local medical
30 society may convene a panel of physicians and surgeons who
31 practice in the area represented by the local medical society to
32 hear and attempt to resolve a dispute involving reimbursement
33 between the contracting physician group or the noncontracting
34 physician or physician group.

35 (b) The panel shall consist of no less than three and no more
36 than five members who represent contracting physician groups
37 and noncontracting physicians or physician groups, and the
38 specialty involved in the dispute.

1 (c) *The members of the panel shall not be affiliated with, under*
2 *contract with, employed by, or have any financial interest in the*
3 *parties to the dispute.*

4 (d) *Neither the contracting physician group nor the*
5 *noncontracting physician or physician group shall be required to*
6 *participate in the process established under this article.*

7 (e) *The panel may attempt to resolve the dispute. If the panel*
8 *determines that the parties are unwilling to agree, the panel shall*
9 *issue an advisory letter to each party setting forth the panel's*
10 *opinion of the appropriateness of the claims of each party. This*
11 *latter shall not be binding on either party, but may be admissible*
12 *in any court action.*

13 (f) *The expenses of the panel and of the process shall be borne*
14 *equally by each of the participating parties, unless the parties*
15 *agree to a different manner of paying the expenses. The local*
16 *medical society may charge a reasonable administrative fee for its*
17 *role in convening and overseeing the panel.*

18 (g) *The local medical society shall not be liable for damages to*
19 *the contracting physician group or the noncontracting physician*
20 *or physician group for its oversight of the process established by*
21 *this section, other than those caused by fraudulent, capricious,*
22 *arbitrary, or otherwise illegal behavior of the local medical*
23 *society or its representatives.*

24 SEC. 2. *Section 1371.35 of the Health and Safety Code is*
25 *amended to read:*

26 1371.35. (a) A health care service plan, including a
27 specialized health care service plan, shall reimburse each complete
28 claim, or portion thereof, whether in state or out of state, as soon
29 as practical, but no later than 30 working days after receipt of the
30 complete claim by the health care service plan, or if the health care
31 service plan is a health maintenance organization, 45 working days
32 after receipt of the complete claim by the health care service plan.
33 However, a plan may contest or deny a claim, or portion thereof,
34 by notifying the claimant, in writing, that the claim is contested or
35 denied, within 30 working days after receipt of the claim by the
36 health care service plan, or if the health care service plan is a health
37 maintenance organization, 45 working days after receipt of the
38 claim by the health care service plan. The notice that a claim, or
39 portion thereof, is contested shall identify the portion of the claim
40 that is contested, by revenue code, and the specific information

needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider

1 shall provide the plan reasonable relevant information within 10
2 working days of receipt of a written request that is clear and
3 specific regarding the information sought. If, as a result of
4 reviewing the reasonable relevant information, the plan requires
5 further information, the plan shall have an additional 15 working
6 days after receipt of the reasonable relevant information to request
7 the further information, notwithstanding any time limit to the
8 contrary in this section, at which time the claim shall be deemed
9 complete.

10 (d) This section shall not apply to claims about which there is
11 evidence of fraud and misrepresentation, to eligibility
12 determinations, or in instances where the plan has not been granted
13 reasonable access to information under the provider's control. A
14 plan shall specify, in a written notice sent to the provider within the
15 respective 30- or 45-working days of receipt of the claim, which,
16 if any, of these exceptions applies to a claim.

17 (e) If a claim or portion thereof is contested on the basis that the
18 plan has not received information reasonably necessary to
19 determine payer liability for the claim or portion thereof, then the
20 plan shall have 30 working days or, if the health care service plan
21 is a health maintenance organization, 45 working days after receipt
22 of this additional information to complete reconsideration of the
23 claim. If a claim, or portion thereof, undergoing reconsideration
24 is not reimbursed by delivery to the claimant's address of record
25 within the respective 30 or 45 working days after receipt of the
26 additional information, the plan shall pay the greater of fifteen
27 dollars (\$15) per year or interest at the rate of 15 percent per annum
28 beginning with the first calendar day after the 30- or
29 45-working-day period. A health care service plan shall
30 automatically include the fifteen dollars (\$15) per year or interest
31 due in the payment made to the claimant, without requiring a
32 request therefor.

33 (f) The obligation of the plan to comply with this section shall
34 not be deemed to be waived when the plan requires its medical
35 groups, independent practice associations, or other contracting
36 entities to pay claims for covered services. This section shall not
37 be construed to prevent a plan from assigning, by a written
38 contract, the responsibility to pay interest and late charges
39 pursuant to this section to medical groups, independent practice
40 associations, or other entities.

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

(l) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

(m) *(1) A plan shall not reimburse a noncontracting provider if all of the following apply:*

(A) The plan has an agreement with a contracting provider that requires the contracting provider to reimburse noncontracting providers for specified services.

(B) The noncontracting provider submits a claim to the contracting provider and the contracting provider disputes the amount of the claim.

(C) The contracting provider notifies the plan that it is disputing the claim.

(2) If a contracting provider disputes a claim pursuant to this subdivision, the plan shall not reimburse the noncontracting provider for any amount of the disputed claim.

(3) If the plan does reimburse the noncontracting provider for any amount of the disputed claim, the plan shall not deduct any part of this amount from any payment the plan owes to the contracting provider.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

1 *for a crime or infraction, within the meaning of Section 17556 of*
2 *the Government Code, or changes the definition of a crime within*
3 *the meaning of Section 6 of Article XIII B of the California*
4 *Constitution.*
5 ~~health care providers who do not contract with a health care service~~
6 ~~plan engage in improper billing practices causing reimbursement~~
7 ~~disputes among providers. In addition, certain of these providers~~
8 ~~attempt to bill patients for the difference between billed charges~~
9 ~~and the reimbursement received from a health care service plan or~~
10 ~~a contracting provider. Therefore, it is the intent of the Legislature~~
11 ~~that these providers who do not contract with a health care service~~
12 ~~plan cease these unfair billing practices.~~

